Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA Central Alabama HCS (VAMC Montgomery - 619 and VAMC Tuskegee - 619A4)

VISN 7

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 375

2. Point-in-time estimate of Veterans who are Chronically Homeless: 84

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **375** (point-in-time estimate of homeless veterans in service area) **X 24%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 95%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 84** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	242	12
Transitional Housing Beds	112	35
Permanent Housing Beds	10	80

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Continue to work with established homeless providers and cultivate interested entities to pursue contracts with VA Healthcare for Homeless Veterans (HCHV) program and/or VA Grant and Per Diem projects.
Dental Care	Continue to negotiate with local dentists to provide low-cost, no-cost dental services to homeless veterans.
Drop-in Center or Day Program	Develop in conjunction with local task forces a comprehensive proposal for a drop-in center.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 18 Non-VA staff Participants: 56% Homeless/Formerly Homeless: 22%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.17	10%	2.39	3
2	Legal assistance	2.23	10%	2.61	4
3	Long-term, permanent housing	2.33	30%	2.25	1
4	Dental care	2.38	10%	2.34	2
5	Drop-in center or day program	2.57	10%	2.77	10
6	Halfway house or transitional living facility	2.71	10%	2.76	8
7	Welfare payments	2.75	0%	2.97	16
8	SSI/SSD process	2.77	0%	3.02	19
9	Treatment for dual diagnosis	2.8	0%	3.01	18
10	Eye care	2.92	0%	2.65	5
11	Emergency (immediate) shelter	3	60%	3.04	20
12	Detoxification from substances	3	0%	3.11	22
13	Services for emotional or psychiatric problems	3	0%	3.20	25
14	Education	3	0%	2.88	13
15	Hepatitis C testing	3.08	0%	3.41	32
16	Glasses	3.08	0%	2.67	6
17	Help managing money	3.08	10%	2.71	7
18	Family counseling	3.13	0%	2.85	12
19	AIDS/HIV testing/counseling	3.14	0%	3.38	30
20	Treatment for substance abuse	3.15	10%	3.30	28
21	Help with transportation	3.15	10%	2.82	11
22	Discharge upgrade	3.17	0%	2.90	15
23	Guardianship (financial)	3.18	0%	2.76	9
24	TB treatment	3.36	0%	3.45	33
25	VA disability/pension	3.38	10%	3.33	29
26	Job training	3.42	10%	2.88	14
27	TB testing	3.43	0%	3.58	36
28	Help with finding a job or getting employment	3.46	0%	3.00	17
29	Women's health care	3.5	0%	3.09	21
30	Help getting needed documents or identification	3.54	0%	3.16	23
31	Medical services	3.6	0%	3.55	34
32	Help with medication	3.6	0%	3.18	24
33	Clothing	3.64	0%	3.40	31
34	Personal hygiene (shower, haircut, etc.)	3.86	0%	3.21	26
35	Food	4	10%	3.56	35
36	Spiritual	4.31	0%	3.30	27

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.86	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.64	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.93	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.36	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.21	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.14	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.18	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.83	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.5	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.08	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.91	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.67	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.42	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.33	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.83	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.92	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC - Augusta, GA - 509

VISN 7

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1792

2. Point-in-time estimate of Veterans who are Chronically Homeless: 468

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1792** (point-in-time estimate of homeless veterans in service area) **X 29%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 90%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 468** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	304	2
Transitional Housing Beds	188	12
Permanent Housing Beds	0	5

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to offer collaboration/supportive documentation in community initiatives to develop permanent housing.
Child Care	Collaborate with Miracle Making Ministries which has developed a child care program for indigent families.
Transitional living facility	Provide information about current NOFA's (e.g., GPD, PDO, HUD, DOL). Develop five new transitional beds.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 53 Non-VA staff Participants: 83%
Homeless/Formerly Homeless: 6%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.74	23%	2.25	1
2	Child care	2.08	5%	2.39	3
3	Dental care	2.21	8%	2.34	2
4	Halfway house or transitional living facility	2.3	26%	2.76	8
5	Eye care	2.33	3%	2.65	5
6	Drop-in center or day program	2.34	8%	2.77	10
7	Guardianship (financial)	2.36	0%	2.76	9
8	Glasses	2.41	0%	2.67	6
9	Help with transportation	2.42	0%	2.82	11
10	Legal assistance	2.5	3%	2.61	4
11	Emergency (immediate) shelter	2.53	26%	3.04	20
12	Help managing money	2.53	3%	2.71	7
13	Education	2.55	5%	2.88	13
14	SSI/SSD process	2.59	8%	3.02	19
15	Discharge upgrade	2.64	0%	2.90	15
16	Welfare payments	2.69	3%	2.97	16
17	Job training	2.7	13%	2.88	14
18	Family counseling	2.76	0%	2.85	12
19	Women's health care	2.76	8%	3.09	21
20	Help with medication	2.82	3%	3.18	24
21	Detoxification from substances	2.89	8%	3.11	22
22	Spiritual	2.92	0%	3.30	27
23	Hepatitis C testing	2.97	0%	3.41	32
24	VA disability/pension	2.97	8%	3.33	29
25	Help with finding a job or getting employment	2.97	15%	3.00	17
26	AIDS/HIV testing/counseling	3	0%	3.38	30
27	Help getting needed documents or identification	3	3%	3.16	23
28	Treatment for substance abuse	3.16	8%	3.30	28
29	Treatment for dual diagnosis	3.16	3%	3.01	18
30	Personal hygiene (shower, haircut, etc.)	3.19	3%	3.21	26
31	TB treatment	3.22	0%	3.45	33
32	Services for emotional or psychiatric problems	3.23	3%	3.20	25
33	TB testing	3.24	0%	3.58	36
34	Medical services	3.33	10%	3.55	34
35	Clothing	3.5	0%	3.40	31
36	Food	3.63	3%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.22	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.93	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.48	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.98	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.5	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.85	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.31	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.49	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.33	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.87	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.02	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.2	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.74	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.74	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.15	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.77	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.82	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.74	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.97	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Atlanta, GA - 508 (Decatur, GA)

VISN 7

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1800

2. Point-in-time estimate of Veterans who are Chronically Homeless: 399

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1800** (point-in-time estimate of homeless veterans in service area) **X 26%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 87%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 399** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	457	175
Transitional Housing Beds	324	50
Permanent Housing Beds	160	130

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 15

3. CHALENG Point of Contact Action Plan for FY 2005

Dental Care	Case managers will continue to refer veterans to VA Dental Services for treatment under the provision of the VHA Directive 2002-80. Additionally, case managers will continue to collaborate with community agencies for procurement of low-cost dental services for the homeless population.
Glasses	Case managers will continue to work with community agencies/non-profit agencies that offer visual screening for homeless veterans and other low-income persons to secure needed services (glasses, glaucoma screening, prescriptions). Veterans will be advised to request prescriptions for corrective vision wear when need is determined.
Transitional living facility	Homeless staff will continue to conduct aggressive and extensive outreach to connect and interact with community organizations in effort to convey needs of homeless veterans' population regarding housing and other shelter needs. Continued participation in community meetings that address the needs of the homeless population will be crucial in promoting VA Per Diem funding to increase beds in the community. Additional beds will be available for utilization via the Per Diem program and 24/7, a partnership with the city of Atlanta.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 45 Non-VA staff Participants: 58% Homeless/Formerly Homeless: 13%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.63	0%	2.39	3
2	Emergency (immediate) shelter	2.72	13%	3.04	20
3	Drop-in center or day program	2.75	9%	2.77	10
4	Long-term, permanent housing	2.8	16%	2.25	1
5	Help with transportation	2.85	20%	2.82	11
6	Help managing money	2.88	0%	2.71	7
7	Family counseling	2.89	2%	2.85	12
8	Dental care	2.97	36%	2.34	2
9	Eye care	3	2%	2.65	5
10	Detoxification from substances	3.03	7%	3.11	22
11	Glasses	3.03	16%	2.67	6
12	Welfare payments	3.03	0%	2.97	16
13	Job training	3.03	13%	2.88	14
14	Guardianship (financial)	3.06	0%	2.76	9
15	SSI/SSD process	3.13	0%	3.02	19
16	Personal hygiene (shower, haircut, etc.)	3.14	0%	3.21	26
17	Legal assistance	3.15	0%	2.61	4
18	Halfway house or transitional living facility	3.2	22%	2.76	8
19	Help with finding a job or getting employment	3.22	9%	3.00	17
20	Education	3.26	0%	2.88	13
21	Discharge upgrade	3.26	2%	2.90	15
22	Treatment for dual diagnosis	3.32	2%	3.01	18
23	Help getting needed documents or identification	3.38	2%	3.16	23
24	Clothing	3.4	0%	3.40	31
25	Food	3.45	2%	3.56	35
26	Help with medication	3.48	0%	3.18	24
27	Women's health care	3.5	0%	3.09	21
28	Services for emotional or psychiatric problems	3.55	0%	3.20	25
29	VA disability/pension	3.55	4%	3.33	29
30	Treatment for substance abuse	3.57	9%	3.30	28
31	Spiritual	3.65	2%	3.30	27
32	Medical services	3.68	4%	3.55	34
33	AIDS/HIV testing/counseling	3.76	4%	3.38	30
34	Hepatitis C testing	3.82	0%	3.41	32
35	TB treatment	3.94	0%	3.45	33
36	TB testing	4.03	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.49	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.38	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.06	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.11	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.97	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.14	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.97	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.97	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.39	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.27	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.17	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.46	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.91	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.92	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.22	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.87	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.88	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.04	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.04	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Birmingham, AL - 521

VISN 7

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 840

2. Point-in-time estimate of Veterans who are Chronically Homeless: 282

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **840** (point-in-time estimate of homeless veterans in service area) **X 34%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 99%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 282** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	65	15
Transitional Housing Beds	47	15
Permanent Housing Beds	60	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	We plan to request additional halfway house funds from the VISN and the local medical center.
Long-term, permanent housing	We plan to pursue 15 additional long-term housing slots during FY 2005. We are already working very closely with HUD.
Help with finding a job or getting employment	We plan to secure more job placement slots in the community. We also plan to request a vocational rehabilitation professional who will assist with job placement and looking after the clients that are placed in employment.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 10 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	1.75	0%	2.39	3
2	Dental care	1.88	11%	2.34	2
3	Family counseling	2	0%	2.85	12
4	Help with medication	2	11%	3.18	24
5	Education	2	0%	2.88	13
6	Long-term, permanent housing	2.11	60%	2.25	1
7	Drop-in center or day program	2.11	11%	2.77	10
8	Help with transportation	2.11	0%	2.82	11
9	Legal assistance	2.11	0%	2.61	4
10	Eye care	2.13	0%	2.65	5
11	Discharge upgrade	2.14	0%	2.90	15
12	Help managing money	2.22	0%	2.71	7
13	Emergency (immediate) shelter	2.25	33%	3.04	20
14	Services for emotional or psychiatric problems	2.25	22%	3.20	25
15	Treatment for dual diagnosis	2.25	0%	3.01	18
16	Glasses	2.25	0%	2.67	6
17	Halfway house or transitional living facility	2.33	0%	2.76	8
18	Detoxification from substances	2.33	11%	3.11	22
19	Treatment for substance abuse	2.44	22%	3.30	28
20	Help with finding a job or getting employment	2.44	11%	3.00	17
21	Job training	2.56	0%	2.88	14
22	Women's health care	2.75	0%	3.09	21
23	Guardianship (financial)	2.78	0%	2.76	9
24	TB treatment	2.88	0%	3.45	33
25	SSI/SSD process	2.89	0%	3.02	19
26	Help getting needed documents or identification	2.89	0%	3.16	23
27	TB testing	3	0%	3.58	36
28	Welfare payments	3.11	0%	2.97	16
29	Personal hygiene (shower, haircut, etc.)	3.25	0%	3.21	26
30	Hepatitis C testing	3.25	0%	3.41	32
31	Spiritual	3.38	0%	3.30	27
32	Medical services	3.44	0%	3.55	34
33	Food	3.5	0%	3.56	35
34	Clothing	3.5	0%	3.40	31
35	VA disability/pension	3.56	0%	3.33	29
36	AIDS/HIV testing/counseling	3.63	11%	3.38	30

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.8	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.22	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.11	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.78	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.2	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.9	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.56	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.3	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.5	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.22	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.44	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.56	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.38	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.13	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.86	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.22	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.14	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.14	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Charleston, SC - 534

VISN 7

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 490

2. Point-in-time estimate of Veterans who are Chronically Homeless: 126

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **490** (point-in-time estimate of homeless veterans in service area) **X 27%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 95%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 126** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	233	189
Transitional Housing Beds	200	200
Permanent Housing Beds	105	75

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	We will work with the local HUD Continuum of Care to support proposals to fund low-income affordable permanent housing.
Help with finding a job or getting employment	Continue to support and refer veterans to Goodwill's Homeless Veterans Reintegration Program.
Help with Transportation	Work with local Continuum of Care to support proposals to fund and expand bus services.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 17 Non-VA staff Participants: 94%
Homeless/Formerly Homeless: 18%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.69	50%	2.25	1
2	Legal assistance	2.33	0%	2.61	4
3	Halfway house or transitional living facility	2.38	25%	2.76	8
4	Help with transportation	2.5	25%	2.82	11
5	Dental care	2.57	8%	2.34	2
6	Drop-in center or day program	2.69	0%	2.77	10
7	Guardianship (financial)	2.69	0%	2.76	9
8	Child care	2.69	0%	2.39	3
9	Help managing money	2.71	17%	2.71	7
10	Eye care	2.79	8%	2.65	5
11	Glasses	2.79	0%	2.67	6
12	VA disability/pension	3	8%	3.33	29
13	Welfare payments	3	0%	2.97	16
14	Job training	3	0%	2.88	14
15	Education	3	0%	2.88	13
16	SSI/SSD process	3.08	0%	3.02	19
17	Emergency (immediate) shelter	3.13	8%	3.04	20
18	Spiritual	3.15	0%	3.30	27
19	Discharge upgrade	3.17	0%	2.90	15
20	Treatment for dual diagnosis	3.2	0%	3.01	18
21	Services for emotional or psychiatric problems	3.21	0%	3.20	25
22	Help getting needed documents or identification	3.23	8%	3.16	23
23	Family counseling	3.33	8%	2.85	12
24	Detoxification from substances	3.4	0%	3.11	22
25	Help with finding a job or getting employment	3.42	25%	3.00	17
26	Women's health care	3.43	0%	3.09	21
27	Help with medication	3.44	8%	3.18	24
28	Clothing	3.67	0%	3.40	31
29	Treatment for substance abuse	3.71	0%	3.30	28
30	AIDS/HIV testing/counseling	3.71	0%	3.38	30
31	Hepatitis C testing	3.75	0%	3.41	32
32	Food	3.8	0%	3.56	35
33	Personal hygiene (shower, haircut, etc.)	3.86	0%	3.21	26
34	TB treatment	3.93	0%	3.45	33
35	Medical services	4	0%	3.55	34
36	TB testing	4	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.07	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.53	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.71	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.14	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.79	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.14	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.79	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.43	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.54	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.36	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.77	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.85	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.08	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.23	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.7	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.23	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.08	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.25	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Columbia, SC - 544

VISN 7

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 800

2. Point-in-time estimate of Veterans who are Chronically Homeless: 237

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **800** (point-in-time estimate of homeless veterans in service area) **X 35%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 86%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 237** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	300	16
Transitional Housing Beds	18	20
Permanent Housing Beds	5	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Help with finding a job or getting employment	Continue excellent working relationship with the One-Stop and expand it to additional counties in the state. Also, maintain our working relationship with SC RV and the WIA to refer veterans for needed training.
Long-term, permanent housing	Continue work with South Carolina Housing Authority to refer for assistance and purchasing permanent housing. Also, have submitted a proposal for transitional residence to better prepare a successful move into independent housing.
Treatment for Dual Diagnosis	Educate community programs. Referred as indicated and monitor in weekly intensive case management appointments.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 24 Non-VA staff Participants: 75%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2	16%	2.25	1
2	Child care	2.11	0%	2.39	3
3	Drop-in center or day program	2.15	0%	2.77	10
4	Dental care	2.62	0%	2.34	2
5	Personal hygiene (shower, haircut, etc.)	2.67	0%	3.21	26
6	Glasses	2.67	0%	2.67	6
7	Halfway house or transitional living facility	2.7	11%	2.76	8
8	Women's health care	2.7	5%	3.09	21
9	Emergency (immediate) shelter	2.74	16%	3.04	20
10	Legal assistance	2.74	5%	2.61	4
11	Help with transportation	2.75	11%	2.82	11
12	Treatment for dual diagnosis	2.77	16%	3.01	18
13	Eye care	2.81	5%	2.65	5
14	Job training	2.86	16%	2.88	14
15	Help managing money	2.89	5%	2.71	7
16	AIDS/HIV testing/counseling	2.9	11%	3.38	30
17	Family counseling	2.91	0%	2.85	12
18	Help with medication	2.95	5%	3.18	24
19	TB treatment	2.95	0%	3.45	33
20	Detoxification from substances	3	0%	3.11	22
21	Guardianship (financial)	3	0%	2.76	9
22	TB testing	3.05	0%	3.58	36
23	Discharge upgrade	3.06	11%	2.90	15
24	Treatment for substance abuse	3.09	16%	3.30	28
25	Services for emotional or psychiatric problems	3.09	5%	3.20	25
26	Hepatitis C testing	3.1	0%	3.41	32
27	Help with finding a job or getting employment	3.19	16%	3.00	17
28	SSI/SSD process	3.3	0%	3.02	19
29	Welfare payments	3.32	0%	2.97	16
30	Education	3.35	0%	2.88	13
31	Medical services	3.36	11%	3.55	34
32	Help getting needed documents or identification	3.43	0%	3.16	23
33	Spiritual	3.47	0%	3.30	27
34	VA disability/pension	3.48	11%	3.33	29
35	Food	3.52	5%	3.56	35
36	Clothing	3.52	0%	3.40	31

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.55	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.18	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.86	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.32	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.14	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.91	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.76	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.62	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.94	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.47	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.41	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.56	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.88	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.65	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.75	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.29	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.88	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.76	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.93	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.94	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Dublin, GA - 557

VISN 7

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 800

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **800** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	350	300
Transitional Housing Beds	0	25
Permanent Housing Beds	0	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Attempt to increase beds.
Help with finding a job or getting employment	Increase vocational rehabilitation resources and Compensated Work Therapy positions.
Help with Transportation	Identify transportation alternatives.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 27 Non-VA staff Participants: 92%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.56	22%	2.25	1
2	Drop-in center or day program	2.56	9%	2.77	10
3	Child care	2.57	13%	2.39	3
4	Welfare payments	2.68	0%	2.97	16
5	Help with transportation	2.68	9%	2.82	11
6	Education	2.73	13%	2.88	13
7	Discharge upgrade	2.76	0%	2.90	15
8	SSI/SSD process	2.8	4%	3.02	19
9	Guardianship (financial)	2.82	0%	2.76	9
10	Help managing money	2.82	9%	2.71	7
11	Halfway house or transitional living facility	2.88	13%	2.76	8
12	Eye care	2.96	9%	2.65	5
13	Glasses	2.96	0%	2.67	6
14	VA disability/pension	3.09	13%	3.33	29
15	Legal assistance	3.09	0%	2.61	4
16	Women's health care	3.13	0%	3.09	21
17	Dental care	3.13	4%	2.34	2
18	Treatment for dual diagnosis	3.17	9%	3.01	18
19	Help with medication	3.17	4%	3.18	24
20	Spiritual	3.18	4%	3.30	27
21	Family counseling	3.22	0%	2.85	12
22	Job training	3.39	4%	2.88	14
23	Detoxification from substances	3.42	4%	3.11	22
24	TB treatment	3.45	0%	3.45	33
25	Hepatitis C testing	3.45	0%	3.41	32
26	Help getting needed documents or identification	3.48	4%	3.16	23
27	Services for emotional or psychiatric problems	3.5	9%	3.20	25
28	AIDS/HIV testing/counseling	3.52	4%	3.38	30
29	TB testing	3.52	0%	3.58	36
30	Medical services	3.54	0%	3.55	34
31	Help with finding a job or getting employment	3.55	13%	3.00	17
32	Treatment for substance abuse	3.56	13%	3.30	28
33	Personal hygiene (shower, haircut, etc.)	3.61	0%	3.21	26
34	Emergency (immediate) shelter	3.63	9%	3.04	20
35	Food	3.79	4%	3.56	35
36	Clothing	3.79	0%	3.40	31

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	2.96	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.88	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.4	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.64	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.32	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.56	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.32	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.44	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.29	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.95	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.28	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.82	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.53	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.71	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.65	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.71	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.65	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.65	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.76	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Tuscaloosa, AL - 679

VISN 7

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 50

2. Point-in-time estimate of Veterans who are Chronically Homeless: 13

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **50** (point-in-time estimate of homeless veterans in service area) **X 27%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 96%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 13** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	40	15
Transitional Housing Beds	8	10
Permanent Housing Beds	0	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	CHALENG group will continue to partner with mental health task force to develop housing complex. CHALENG group has also partnered with Tuscaloosa Housing Authority to apply for a HUD Shelter Plus Care grant to provide additional Section 8 vouchers. Grant application is currently pending.
Immediate shelter	CHALENG group will continue to encourage new shelter programs to participate in meetings and assist in developing better working relationship with VA and other service agencies.
Transitional living facility	CHALENG group will explore options of increasing transitional housing beds, especially for those that have SMI diagnosis with various service providers.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 31 Non-VA staff Participants: 87%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	1.86	8%	2.39	3
2	Long-term, permanent housing	1.89	50%	2.25	1
3	Glasses	1.96	0%	2.67	6
4	Eye care	2	8%	2.65	5
5	Dental care	2.04	12%	2.34	2
6	Legal assistance	2.26	4%	2.61	4
7	Drop-in center or day program	2.31	0%	2.77	10
8	Family counseling	2.41	8%	2.85	12
9	Guardianship (financial)	2.62	0%	2.76	9
10	Help with transportation	2.63	0%	2.82	11
11	Help managing money	2.7	0%	2.71	7
12	Welfare payments	2.73	0%	2.97	16
13	Halfway house or transitional living facility	2.75	19%	2.76	8
14	Personal hygiene (shower, haircut, etc.)	2.79	8%	3.21	26
15	Discharge upgrade	2.79	0%	2.90	15
16	Education	2.82	0%	2.88	13
17	Women's health care	2.86	0%	3.09	21
18	SSI/SSD process	2.89	0%	3.02	19
19	Detoxification from substances	2.93	4%	3.11	22
20	Help getting needed documents or identification	2.93	0%	3.16	23
21	Help with finding a job or getting employment	2.96	4%	3.00	17
22	Emergency (immediate) shelter	3.1	27%	3.04	20
23	VA disability/pension	3.11	8%	3.33	29
24	Job training	3.11	0%	2.88	14
25	Spiritual	3.11	4%	3.30	27
26	Medical services	3.14	15%	3.55	34
27	Help with medication	3.14	0%	3.18	24
28	Hepatitis C testing	3.14	0%	3.41	32
29	Food	3.17	4%	3.56	35
30	AIDS/HIV testing/counseling	3.18	0%	3.38	30
31	Clothing	3.21	0%	3.40	31
32	TB treatment	3.21	0%	3.45	33
33	Treatment for substance abuse	3.24	8%	3.30	28
34	Treatment for dual diagnosis	3.32	0%	3.01	18
35	TB testing	3.41	0%	3.58	36
36	Services for emotional or psychiatric problems	3.55	8%	3.20	25

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.87	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.13	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.93	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.03	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.93	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.63	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.3	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.37	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.79	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.25	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.42	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.92	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.71	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.92	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.71	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.13	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.71	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.67	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.92	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.92	1.84